Camp Sunshine

"Where **HOPE** outshines grief"

CAMPER APPLICATION PART 2 - please print
(To be completed by the Parent/Legal Guardian)

_____ ☐ Female ☐ Male
Legal Name of the Camper

_____ _____ ____
Name to appear on camp name badge Birth Date (MM/DD/YYY) Age

_____ _____
Parent/Legal Guardian Name Relationship

_____ _____ _____
Address Town Postal Code

_____ _____ _____
Phone (Home) (Work) (Cell)

_____
Your email address

How do you think this camp will benefit your child?
_____
_____
_____

Bereavement History, please include as many details as possible when answering the following questions. Your care and concern will help us a great deal.

Who was the person that died? (Name) _____
Relationship to the child _____
Date of death _____
Age of the person who died _____
Cause of death _____
Was the child present when the person died? ☐ Yes ☐ No

What was the relationship like between the child and their loved one who died?

_____
_____
_____
_____

Did the child attend the funeral/memorial? ☐ Yes ☐ No
How does your child show that he/she is grieving? (ie sadness, anger, acting out, changes in eating and sleeping patterns, withdrawn, school performance, etc.)

_____
_____
_____
_____
_____

Have there been any other changes/stresses in the child's life? (Such as divorce/ separation, friend or family member moving, illness, changing schools, or other losses) ☐ Yes ☐ No If "yes", when did the changes occur? _____

_____

Other information you believe might be helpful for Camp Sunshine staff to know:

_____
_____
_____

Health History

In case of an emergency and the parent/guardian cannot be reached, please notify:

_____ _____ _____
Name Relationship Daytime Phone

Medications: My camper ☐ will NOT ☐ WILL take daily medication while at camp.
If your child **WILL** be taking medication during Camp Sunshine, please provide to us:

1. Child's Doctor Name & Phone # _____
2. Bring the Medication in its original container, with a Medication schedule (time of day that medication is to be taken and dose).

3. Your permission to have our Camp Director supervise and schedule the taking of all medication by your child.

Check any conditions that apply to your child:

☐ Asthma ☐ Epilepsy ☐ Kidney Problems ☐ Heart Problems
☐ Diabetes ☐ Allergies ☐ Eating Disorder ☐ Other _____

If you checked allergies, please complete list below:

1. Allergic to: _____
   Treatment/Medication: _____
2. Allergic to: _____
   Treatment/Medication: _____
3. Allergic to: _____
   Treatment/Medication: _____

Will your child be bringing an EPI pen? ☐ Yes ☐ No
Does your child use an inhaler? ☐ Yes ☐ No
Please list any special dietary restrictions or needs:

_____
_____

Please list any physical activities in which your child should NOT participate.

_____
_____

NOTE: All of the information collected is for Sunshine Camp personnel to help make Camp a safe and successful experience for your child. It will be held in strictest confidence.

PERMISSION/AUTHORIZATION

I give permission for the Camp Director to supervise my child's prescription medication schedule (correct dose and correct times) that I have provided to Camp Sunshine.

_____ _____
Parent/Legal Guardian Date

In the event of an emergency, I give Camp Sunshine authorization to seek emergency care at the local hospital. In the event that either I or my alternate

emergency contact is not available, I give permission for the Doctor at the hospital to provide proper treatment and appropriate care for my child as deemed necessary. I agree that I am responsible for care rendered to my child and will indemnify and hold harmless Camp Sunshine staff, volunteers, service providers, directors, and medical staff.
I certify that the information submitted on this application is accurate.

_____ _____
Parent/Legal Guardian Date

I agree to allow photos or video of my child to be taken at camp and be used for
promotion of Sunshine Camp and for training purposes. The personal information collected by St Paul Regional FCSS is necessary to operate our Camp Sunshine program. This collection is authorized by section 33 of the Freedom of Information and Protection of Privacy Act.

_____ _____
Parent/Legal Guardian Date

There will be a special
Closing Celebration & Ceremony of Remembrance
on Thursday, **July 11th at 3:00 pm** which your family is invited to attend.
Campers will be preparing the ceremony and it will be an
important part of their grief journey.
Please indicate the number of family members who
will attend #_____

Thank You!